NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1995, each agency shall begin the rulemaking process by first filing a Notice of Proposed Rulemaking, containing the preamble and the full text of the rules, with the Secretary of State's Office. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the Arizona Administrative Register.

Under the Administrative Procedure Act (A.R.S. § 41-1001 *et seq.)*, an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 8. DEPARTMENT OF ECONOMIC SECURITY - ~~OLDER AMERICANS~~ AGING AND ADULT ADMINISTRATION

PREAMBLE

1. Sections Affected: / Rulemaking Action:

R6-8-205	Repeal
R6-8-205	New Section
R6-8-206	Repeal
R6-8-206	New Section
R6-8-207	Repeal
R6-8-207	New Section
R6-8-208	Repeal
R6-8-208	New Section
R6-8-209	Repeal
R6-8-209	New Section
R6-8-210	Repeal
R6-8-210	New Section
R6-8-211	Repeal
R6-8-211	New Section
R6-8-212	Repeal
R6-8-212	New Section
R6-8-213	Repeal
R6-8-213	New Section
R6-8-214	Repeal
R6-8-214	New Section
R6-8-215	Repeal
R6-8-216	Repeal
R6-8-217	Repeal
R6-8-218	Repeal
R6-8-219	Repeal
R6-8-220	Repeal
R6-8-221	Repeal
R6-8-222	Repeal
R6-8-223	Repeal
R6-8-224	Repeal

2. The specific authority for rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 41-1954(A)(3) and 46-134(12)

Implementing statutes: A.R.S. §§ 46-451, 46-452, 46-453, 46-454, and 46-455

3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Vista Thompson Brown

   Address: Department of Economic Security
   P.O. Box 6123, Site Code 837A
   Phoenix, Arizona 85005

   Telephone: (602) 542-6555

   Fax: (602) 542-6000

4. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   Arizona started its Adult Protective Services Program (APS) in 1975 pursuant to Title XX of the federal Social Security Act. The current rules were originally adopted in July 1976 to provide guidelines for the operation of social services programs. The rules identify procedures for reporting and investigating allegations of abuse, neglect, or exploitation of incapacitated or vulnerable adults. The rules have not been revised or updated since their implementation. In 1980, the state of Arizona began adopting statutes to operate APS as a mandated program. The APS statutes have been revised and amended since their implementation, and as a result the rules are now outdated. In this rulemaking package, the Department is adopting a new, comprehensive set of rules to govern APS program operations. The new rules will be consistent with current federal and state authority and with current program policy and practice.

   The rules also reflect a recodification. Historically, rules governing the Adult Protective Services (APS) Program have been codified in 6 A.A.C. 5, Article 56. With the exception of the APS rules, the rules in Chapter 5 govern the Department's programs for children and families. Because the APS govern a program that is primarily designed for older persons, these rules are more appropriately codified in Chapter 8, which contains rules applicable to older persons.

   The recodification is also more consistent with the Department's organizational structure and the Divisions which use apply the rules. The Department's Division of Children and Family Services is responsible for the programs using the rules in Chapter 5. The Department's Division of Aging and Community Services is responsible for the programs using the rules in Chapter 8.

5. **A showing of good cause why the rule is necessary to promote statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state.**

   Not applicable.

6. **The preliminary summary of the economic, small business and consumer impact:**

   There will be no economic impact on small businesses as the rules do not change the mandatory reporting requirements established by A.R.S. § 46-454. Consumer impact will also be minimal as the underlying substantive requirements are unchanged. The rules themselves have been updated to include new language and to reflect statutory changes that have occurred during the past 20 years.

7. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

   Name: Vista Thompson Brown

   Address: Department of Economic Security
   P.O. Box 6123, Site Code 837A
   Phoenix, Arizona 85005

   Telephone: (602) 542-6555

   Fax: (602) 542-6000

8. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no preceding is scheduled, where, when and how persons may request an oral proceeding on the proposed rule:**

   A person may submit written comments on the proposed rules or economic impact statement by submitting the comments no later than the close of record, which is scheduled for 5 p.m., April 26, 1996, to the person specified above.

   Oral proceedings are scheduled as follows:

   PHOENIX/DISTRICT I:
   Date: April 25, 1996

   Time: 1:30 p.m.

   Location: DES Conference Room
   815 North 18th Street
   Phoenix, Arizona

   Coordinating Program Manager: Vince Ornelas (602) 255-3722

TUCSON/DISTRICT II:
Date: April 25, 1996

Time: 1:30 p.m.

Location: DES Conference Room
400 West Congress #420
Tucson, Arizona

Coordinating Program Manager: Henry Granillo (520) 628-6810

FLAGSTAFF/DISTRICT III:
Date: April 25, 1996

Time: 1:30 p.m.

Location: DES Conference Room
220 North LeRoux
Flagstaff, Arizona

Coordinating Program Manager: Pam Estrella (520) 779-2731

YUMA/DISTRICT IV:
Date: April 25, 1996

Time: 1:30 p.m.

Location: DES Conference Room
350 West 16th Street
Yuma, Arizona

Coordinating Program Manager: Tim Acuff (520) 782-4342

CASA GRANDE/DISTRICT V:
Date: April 25, 1996

Time: 1:30 p.m.

Location: DES Conference Room
2510 North Trekell
Casa Grande, Arizona

Coordinating Program Manager: Clay Ross (520) 836-2351

BISBEE/DISTRICT VI:
Date: April 25, 1996

Time: 1:30 p.m.

Location: DES Conference Room
209 East Bisbee
Bisbee, Arizona

Coordinating Program Manager: Marty White (520) 432-5703

The Department of Economic Security (DES) follows and supports Title II of the Americans With Disabilities Act. The Department of Economic Security does not discriminate against persons with disabilities who wish to make oral or written comments on the proposed rulemaking or otherwise participate in the public comment process. Persons with disabilities who need accommodation (including auxiliary aids or services) to participate in the above-scheduled hearings may contact the coordinating program managers identified above, at least 72 hours before the scheduled hearing, to request accommodation. To request accommodation to participate in the public comment process or to obtain this notice in large print, Braille, or on audiotape, contact Vista Thompson Brown at (602) 542-6555, P.O. Box 6123, Site 837A, Phoenix, Arizona 85005; TDD Relay (800) 367-8939.

9. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific agency or to any specific rule or class of rules.**
Not applicable.

10. **Incorporations by reference and their locations in the rules:**
Not applicable.

11. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 8. DEPARTMENT OF ECONOMIC SECURITY
~~OLDER AMERICANS~~ AGING AND ADULT ADMINISTRATION

ARTICLE 2. ADULT PROTECTIVE SERVICES

Section

ARTICLE 2. ADULT PROTECTIVE SERVICES

~~R6-8-205. Definitions~~

~~A. "Abuse" means the infliction of physical or mental harm through the action of the adult or others.~~

~~B. "Adult" means an individual 18 years of age and older.~~

~~C. "Adult protective services worker" means a Department of Economic Security employee providing social services in adult protection.~~

~~D. "Alternate living arrangement" means any living arrangement other than own home.~~

~~E. "Caretaker" means a person who has the responsibility for the care of an adult as a result of family relationship or who has assumed the responsibility for the care of the adult. A caretaker under this Chapter is not a guardian.~~

~~F. "Central registry" means a confidential file of all adults reported to be abused, neglected, or exploited.~~

~~G. "Child protective services worker" means a person employed by the Department of Economic Security to provide protective services to children who have been reported abused, abandoned, dependent, and exploited, and to their families.~~

~~H. "Contact" means a personal visit, a telephone call, or a written communication.~~

~~I. "Conservator" is an adult "who may expend or distribute income or principle of the estate without court authorization or confirmation for the support, education, care, or benefit of the protected person and his dependents" (A.R.S. § 14-5425)~~

~~J. "Counseling" means 1 or more discussions between a Department of Economic Security representative and an adult directed at improving individual or family functioning or resolving an identified problem.~~

~~K. "Danger to self" means behavior which constitute a danger to inflicting substantial bodily harm upon oneself, including attempted suicide. Danger to self is not present if the hazards to self are restricted to those which may arise from conditions defined under grave disability (A.R.S. § 36-501).~~

~~L. "Exploitation" means the deprivation of rights and entitlements due to the adult or the wasting of the adult's self or resources by others.~~

~~M. "Felony" means "a crime or public offense which is punishable with death or imprisonment in the state prison" (A.R.S. § 13-103).~~

~~N. "Foster homes" means a private home studied and approved by the Department of Economic Security for adults for non-nursing home needs.~~

~~O. "Gravely disabled" means "a condition in which a person is unable to provide for his basic personal needs for food, clothing, and shelter as a result of a mental disorder of a type which has:~~

~~1. Developed over a long period of time and has been of long duration; or,~~

~~2. Developed as a manifestation of a degenerative brain disease during old age; or,~~

~~3. Developed as a manifestation of some other degenerative physical illness of long duration" (A.R.S. § 36-501).~~

~~P. "Guardian of an incapacitated person" is an individual who "has the same powers, rights, and duties respecting his ward that a parent has respecting his unemancipated minor child except that a guardian is not liable to third persons for acts of the ward solely by reason of the guardianship." (A.R.S. § 14-5312).~~

~~Q. "Hazardous conditions" means a state of physical and environmental circumstance involving risk to life and limb.~~

~~R. "Incapacitated person" means "any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication or other cause, except minority, to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person" (A.R.S. § 14-1501).~~

~~S. "Investigation of initial report" means a systematic inquiry and detailed study by an adult protective service worker to determine reports, oral, or written of alleged abuse, neglect, of exploitation of an adult.~~

~~T. "Law enforcement" means sheriffs, of counties, constables, marshals, and police persons of cities and towns.~~

~~U. "Mental disorder" means "a substantial disorder of the person's emotional processes, thought, cognition, or memory. Mental disorder is distinguished from:~~
~~1. Conditions which are primarily those of drug abuse, alcoholism, or mental retardation;~~
~~2. The declining mental abilities that directly accompany impending death;~~
~~3. Character and personality disorders characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from a mental disorder" (A.R.S. § 36-501).~~

~~V. "Neglect" means the causing of physical or mental harm through the inaction of the individual or others, including but not limited to deprivation of food, shelter, clothing, and medical care.~~

~~W. "Public fiduciary" means a person appointed by the County Board of Supervisors to serve those persons in need of guardianship or conservatorship and for whom there is no person or corporation qualified or willing to act in such capacity.~~

~~X. "Receiving foster home" means a foster home certified by the Department of Economic Security as suitable for immediate placement of adults.~~

~~Y. "Shelter care" means 24-hour, short-term emergency care in a facility approved by the Department of Economic Security.~~

~~Z. "Social services" means services provided by the Department of Economic Security employee to assist families in the resolution of problems affecting social functioning.~~

~~AA. "Voluntary services" means services provided with the consent of the adult.~~

R6-8-205. Definitions

In addition to the definitions in A.R.S. § 46-451, the following definitions apply in this Article unless the context requires otherwise.

1. "Adult" means a person 18 years of age or older.
2. "Adult Protective Services" or "APS" means a program within the Department of Economic Security which provides protective services.
3. "Conservator" means a person who has been appointed by a court to manage the affairs of another, as prescribed in A.R.S. § 14-5401 et seq.
4. *"Danger to self" means:*
   a. *"Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out;*
   b. *Behavior which, as a result of a mental disorder, will, without hospitalization, result in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled".* A.R.S. § 36-501(5).
5. "Department" means the Department of Economic Security.
6. *"Gravely disabled" means "a condition, evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm, or serious illness because he is unable to provide for his basic physical needs".* A.R.S. § 36-501.
7. "Guardian" means a person who has been appointed by a court to manage the affairs of another, as prescribed in A.R.S. § 14-5401 et seq.
8. "Information and referral" means the provision of information or referral to help a person who contacts or is reported to the Department who is not alleged to be abused, neglected, or exploited, to locate, and obtain help with a problem.
9. "Intake" means a duty performed by APS staff in receiving reports or providing information and referral.
10. "Jurisdiction" means the state of Arizona, exclusive of Native American Reservation land.
11. "Life-threatening situation" means a situation or circumstance that is likely to result in death if not corrected by medical or law enforcement intervention.
12. *"Mental disorder" means "a substantial disorder of a person's emotional processes, thought, cognition, or memory. Mental disorder is distinguished from:*
    a. *Conditions which are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to 1 or more of these conditions, the person has a mental disorder;*
    b. *The declining mental abilities that directly accompany impending death; and*
    c. *Character and personality disorders characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from a mental disorder".* A.R.S. § 36-501.
13. "Personally identifiable information" means any information that can indicate a person's identity including:
    a. Name;
    b. Address;
    c. Telephone number;
    d. Fax number;
    e. Photograph;
    f. Fingerprints;
    g. Physical description;
    h. Place, address, or telephone number of employment;
    i. Social security number;
    j. Tribal affiliation;
    k. Tribal identification number;
    l. Driver's license number;
    m. Birthdate;
    n. APS worker narrative; or
    o. Any other identifier specific to an individual.
14. *"Prepetition screening" means the "review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application, and when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services".* A.R.S. § 36-501(30).
15. *"Protected person" means "a minor or any other person for whom a conservator has been appointed or any other protective order has been made".* A.R.S. § 14-5101(4).
16. *"Protective services" means "a program of identifiable and specialized social services that may offer social services appropriate to resolve problems of abuse, exploitation, or neglect of an incapacitated or vulnerable adult".* A.R.S. § 46-451(A)(8).
17. "Record" means a collection of documents, including electronic documents, related to casework about a person reported to APS, or receiving APS services.

18. "Report" means a communication which alleges abuse, neglect, or exploitation of an incapacitated or vulnerable adult, or information regarding an adult who may be in need of protective services.
19. "Special visitation warrant" means an order of the Superior court that is issued as prescribed in A.R.S. § 14-5310.01 and which permits an APS worker, accompanied by a peace officer, to visit the residence of an adult believed to be incapacitated and abused, neglected, or exploited.
20. "Work day" means 8 a.m. to 5 p.m., Monday through Friday, excluding Arizona state holidays.

~~R6-8-206. Guidelines for Screening Adult Protective Services Referrals~~
~~All initial reports, oral or written, of abused, neglected, or exploited adults shall be investigated by an adult protective services worker. The source must provide information concerning the nature and extent of abuse, neglect, and exploitation.~~

R6-8-206. Reporting Requirements for Adult Protective Service Cases
Upon receipt of a report, as prescribed in A.R.S. § 46-454, APS shall ask the reporting source to provide:
1. All information as prescribed in A.R.S. § 46-454(C); and,
2. As much information regarding the allegedly incapacitated, or vulnerable adult as is available to the source including:
   a. The names and addresses of those involved and their roles;
   b. The length of time the situation has been ongoing;
   c. The client's functional level;
   d. Whether other agencies are providing assistance and, if so, what type of assistance; and,
   e. Any other information that may assist the APS worker in the investigation.

~~R6-8-207. Eligibility for Services~~
~~Persons who have attained the age of 18 years, who are harmed or threatened with harm through action or inaction by another individual or through their own ignorance, incompetence, or poor health, resulting in mental abuse, neglect, deprivation of entitlements due them, or wasting of their resources. There must be no one willing and able to provide needed assistance.~~

R6-8-207. Eligibility for Services
To be eligible for APS services, a person shall be:
1. Age 18 years or older;
2. Incapacitated or vulnerable;
3. The victim or alleged victim of abuse, neglect, or exploitation; and,
4. Within the jurisdiction.

~~R6-8-208. Investigation of Initial Report~~
~~A. The visit shall be made immediately if the adult is in danger of imminent physical harm.~~
~~B. The adult shall be visited within 48 hours (excluding Saturdays, Sundays, and state and federal holidays), after receipt of a report of a person who may be in need of adult protective services.~~
~~C. If the adult lives with a caretaker, the caretaker shall be interviewed.~~
~~D. The purpose of the visit is to:~~
~~1. Determine the validity of the report,~~
~~2. Determine how the adult is being affected by the situation.~~
~~E. If a report is determined to be valid, the central registry file will be checked to determine if the adult had been previously referred to the Department of Economic Security.~~

R6-8-208. Jurisdiction
A. An APS worker shall not investigate reports of events which occurred in another state, foreign country, or Indian reservation.
B. When the Department receives a report of alleged abuse, neglect or exploitation of a person who is outside of the jurisdiction, the Department shall make a report to the appropriate state, international, or tribal government or social services agency.

~~R6-8-209. Refusal of Services by the Adult or Guardian~~
~~The adult or guardian has a right to refuse adult protective services. However, if it is believed the adult is incapacitated, further assessment shall be made to determine if legal action is needed.~~

R6-8-209. Classification
At intake, an APS worker shall classify the incoming communication into 1 of the following 3 categories:
1. Information and referral;
2. Report accepted for evaluation and investigation; or
3. Report accepted for evaluation, but not investigation.

~~R6-8-210. Service to Incapacitated Adult~~
~~A. When an adult is harmed or threatened with harm and it appears that he is an incapacitated person needing protection under the law, the adult protective services worker shall take steps to initiate voluntary protection of the person or take action which may cause a petition to be filed for the appointment of a guardian and/or conservator on behalf of the adult, or for court-ordered mental health treatment. If the guardian is abusing, neglecting, or exploiting the adult, the adult protective services worker may cause a petition for a temporary guardian to be filed and/or removal of the present guardian.~~
~~B. In no case shall an adult protective services worker be appointed as guardian.~~

R6-8-210. Investigation
A. Reports accepted for evaluation and investigation:
1. In alleged life-threatening situations, the APS worker shall refer the reporting source or initiate contact with:
   a. Local law enforcement authorities,
   b. Paramedics, or
   c. An emergency medical team.
2. When an APS worker investigates a situation that may present a danger to the APS worker or client, the APS worker may ask law enforcement authorities to participate in the investigation either at the time of the report or upon arrival at the scene.
3. An APS worker shall visit a person who may be in need of adult protective services within 2 work days after receipt of a report.
4. The APS worker shall investigate, determine, and document in the record whether:
   a. The allegations are substantiated,
   b. The client needs services,
   c. The client will accept services,
   d. The client appears able to provide informed consent for the provision of services,
   e. The Department needs to request an outside mental health assessment, or
   f. The Department needs to file for a special visitation warrant.

5. To make the assessment described in subsection (A)(4), the APS worker shall consider all relevant circumstances regarding the client, which may include the following:
   a. The client's appearance,
   b. Identifying information,
   c. Financial information,
   d. Existing protective arrangements,
   e. Physical status including any disabilities,
   f. Medications,
   g. Medical history,
   h. Mental status,
   i. Functional status,
   j. Behavioral status,
   k. Social environment,
   l. Physical environment,
   m. Nutrition,
   n. Services provided by other resources,
   o. The client's perception of the situation, and,
   p. The perception of the client's situation by:
      i. Family,
      ii. Neighbors,
      iii. Caregivers,
      iv. Friends, or
      v. Other concerned parties.

B. Reports Accepted for Evaluation but not Investigation:
APS may classify a report as not accepted for investigation because of:
1. Insufficient information;
2. Sufficient involvement of other resources;
3. The situation is known to APS and the report does not provide additional information; or,
4. The client's need is for placement into a care facility only.

~~**R6-8-211. Guidelines for Determining Need for Ongoing Adult Protective Services**~~
~~A. The adult is in need of protective services and will accept services;~~
~~B. A petition for guardianship/conservatorship is needed, or,~~
~~C. A mental health evaluation is needed.~~

R6-8-211. Case Planning
A. The APS worker shall maintain a case plan for clients in need of protective services.
   1. The case plan shall contain:
      a. Specific goals and objectives,
      b. Outline of casework activities for achieving objectives, and,
      c. Time frames for achieving objectives.
B. An APS worker shall:
   1. Involve the client in identifying and understanding the client's needs and planning of services to address those needs, unless the client's mental or physical condition prevents the client from participating in planning;
   2. Locate persons who can help the client achieve planned goals;
   3. Regularly assess the client's progress towards the goals;
   4. Revise goals to meet the changing needs of the client; and,
   5. Coordinate with other agencies to address the client's needs.

~~**R6-8-212. Reporting Felonies**~~
~~The adult protective services worker must report all felonies that come to his attention to law enforcement. Failure to do so could expose the adult protective services worker to a charge of accomplice or accessory after the fact (A.R.S. § 13-141).~~

R6-8-212. Refusal of Services by the Adult or Guardian
A. An adult may refuse adult protective services.
B. If an APS worker believes that a client in need of services is a danger to self or gravely disabled due to a mental disorder, as prescribed in A.R.S. § 36-501 or in need of a guardianship or conservatorship, the APS worker may obtain further assessment of the client's physical or mental health.
   1. If the assessment determines that the client is a danger to self or gravely disabled due to a mental disorder, as prescribed in A.R.S. § 36-501 or in need of a guardianship or conservatorship APS shall take action to protect the client.
   2. The action may include:
      a. Seeking a special visitation warrant if the APS worker is denied access to a client,
      b. Petitioning for appointment of a conservator or guardian, or
      c. Applying for prepetition screening.
C. A guardian may refuse services on behalf of a protected person.
D. If an APS worker finds that a guardian is not acting in the best interest of a protected person, the APS worker may petition the court to review the guardianship. The petition shall include the specific reasons that the APS worker believes that the guardian is not acting in the best interest of the ward.

~~**R6-8-213. Legal Services in Adult Protective Services**~~
~~A. Consulting with legal services bureau~~
~~1. The adult protective services worker may consult the Department of Economic Security's legal services bureau regarding reporting procedure on felony cases.~~
~~2. The adult protective services worker may contact the legal services bureau for interpretation of laws affecting adults and their rights.~~
~~B. Guardianship of incapacitated persons~~
~~1. The law relating to guardianships of incapacitated persons sets forth priorities for appointment, A.R.S. § 14-5311. The last priority is for "the nominee of a person who is caring for the incapacitated person or paying benefits to him." Under this Section, the Department of Economic Security may nominate an individual to act as guardian.~~
~~2. In no case should an adult protective services worker be appointed as guardian.~~

R6-8-213. Case Closure
APS may close a case when:
1. Allegations of abuse, neglect, or exploitation are not substantiated;
2. The abuse, neglect, or exploitation is successfully resolved;
3. The client's capacity is not in question, and the client is refusing APS involvement or is not accepting viable remedies for prevention of risk;
4. The client is admitted to care in a state institution or other care facility;
5. The client has moved outside the jurisdiction;
6. The client dies;
7. Contact with the client is lost and attempts to reestablish have failed; or,
8. Guardianship or conservatorship is obtained.

~~**R6-8-214. Determining Need for Mental Health Evaluations**~~
~~The adult protective services worker must determine if the adult appears to be a danger to self or gravely disabled as a result of a mental disorder before making an application for screening. (A.R.S. § 36-501).~~

R6-8-214. Confidentiality

A. All personally identifiable information is confidential as prescribed in A.R.S. § 41-1959. A person who is entitled to obtain information pursuant to A.R.S. § 41-1959(C) and who wishes to obtain information shall comply with the requirements of this Section.

B. The requester shall send a written request to the APS program manager for the office where the requester believes the records are located; the request shall include the following information:
   1. The name, address, and telephone number of the person, organization, or entity requesting information;
   2. If the request is on behalf of an organization or entity, the name and title of the person signing the request;
   3. The purpose for which the information is sought;
   4. The Section of A.R.S. § 41-1959(C) authorizing the person to obtain the information;
   5. The name of the client who is the subject of the APS report, with as much of the following information as the requester can provide:
      a. Other possible spellings, names, or aliases of the client;
      b. The approximate date of the APS report; and
      c. Any other data that the requester believes will be likely to assist the Department in identifying the information requested.

C. Upon receipt of a request for information, the Department shall determine if the request is complete. If the request is not complete, the Department shall contact the requester for the missing information.

D. The receipt date is the day that the receiving office designated on the request actually receives the complete request.

E. The Department shall respond to the requester within 15 work days.

F. The person releasing the information shall document in the case record:
   1. The name of the person to whom the information was released,
   2. The date and method of release, and
   3. A description of the information released.

~~R6-8-215. Arranging for Guardian or Conservators~~

~~The county public fiduciary will be contacted to initiate legal procedures for the appointment of a guardian and/or conservator when the adult is determined to be incapacitated but is not a danger to self or gravely disabled due a mental disorder.~~

~~R6-8-216. Arranging for Shelter Care or Receiving Home Care~~

~~A. The Adult Protective Services worker may help the adult find a local resource which can provide over night or short term care.~~

~~B. Placement, with the adult's consent, may be in a shelter care facility or a receiving home.~~

~~R6-8-217. Case Planning~~

~~A. The adult shall be assisted in identifying and understanding his needs and will be involved in case planning whenever capable.~~

~~B. No medical diagnostic information unknown to the adult is discussed with him without consent of his physician, legal guardian, and/or caretaker relative.~~

~~R6-8-218. Ongoing Adult Protective Services~~

~~A. The Adult Protective Services will continue to provide services as long as needed and desired by the adult or his guardian.~~

~~B. Referral may be made to an appropriate Department of Economic Security or community service when Adult Protective Services are no longer needed.~~

~~C. If the adult moves to another county or state before a satisfactory assessment is completed and the address is known, and it is believed the adult is incapacitated and in danger of harm, a request is made to an appropriate Social Service agency in the new county or state of residence to provide protective services.~~

~~R6-8-219. Providing Service to Implement the Casework Plan~~

~~A. The Adult Protective Services worker is required to visit or otherwise contact the adult as necessary to assure that the case is progressing according to plan and to provide assistance where necessary.~~

~~B. The Adult Protective Services worker shall visit or otherwise contact all persons who will, or who might be willing to, help the adult achieve his planned goal.~~

~~R6-8-220. Adult Protective Services Outside of Arizona~~

~~A. The adult protective service worker will not enter another state or foreign country.~~

~~B. All contacts out of Arizona shall be made through the appropriate state or international social services agency.~~

~~R6-8-221. Referrals from Social Services and Child Protective Services~~

~~A. Social services worker or Child Protective Services workers shall refer any 18 year old foster child to Adult Protective Services if the adult is in need of protection.~~

~~B. Social services workers or Child Protective Services workers will refer other adults to Adult Protective Services who need protection.~~

~~R6-8-222. The Central Registry~~

~~Within 30 days after the receipt of the initial information, the Adult Protective Services worker will render a written report to the Central Registry.~~

~~R6-8-223. Adult Protective Services Identification Card~~

~~The Department of Economic Security shall provide a photo identification card for all Adult Protective Services workers.~~

~~R6-8-224. Closure of Adult Protective Services~~

~~A. Adult Protective Services shall be closed when a determination has been made that the adult is no longer in danger or threat of danger and there is no need for protection.~~

~~B. The adult has moved and whereabouts is unknown.~~

~~C. A referral has been made for other Department of Economic Security Social Services or to an appropriate social agency and the family is receiving the necessary services to resolve the referral problem.~~

~~D. The adult terminates service.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 20. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected / Rulemaking Action

Sections Affected	Rulemaking Action
R20-6-1101	Amend
R20-6-1102	Amend
R20-6-1104	Amend
R20-6-1105	Amend
R20-6-1108	Amend
R20-6-1110	Amend
R20-6-1113	Amend
R20-6-1114	Amend
Appendix B	Amend
Appendix C	Amend
Appendix D	Amend
Appendix E	Amend
Appendix F	New Appendix

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

   Authorizing statutes: A.R.S. §§ 20-143 and 20-1133

   Implementing statute: A.R.S. § 20-1133

3. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

   Name: Gregory Y. Harris

   Address: Department of Insurance
   2910 North 44th Street, Suite 210
   Phoenix, Arizona 85018

   Telephone: (602) 912-8451

   Fax: (602) 912-8452

4. An explanation of the rule, including the agency's reasons for initiating the rule:

   Medicare Supplement insurance is regulated by the state based on minimum standards prescribed by federal law. These changes reflect changes to federal law at 42 U.S.C. Sec. 1395 ss (a) and (b). In addition, disclosure forms dictated by federal law will be adopted. Without these changes, Medicare Supplement insurance policies may not be sold in Arizona after April 28, 1996, except as directly regulated by the Federal Department of Health and Human Services/Health Care Financing Administrations (DHHS/HCFA). Now, 42 U.S.C. Sec. 1395 ss (a) and (b) requires DHHS/HCFA to certify that a state's Medicare supplement regulatory program meets the current standards of the Model Medicare Supplement Act and Regulation adopted by the National Association of Insurance Commissioners. These changes precisely mirror the changes required by DHHS/HCFA.

5. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

   Not applicable.

6. The preliminary summary of the economic, small business, and consumer impact:

   These amendments are required by federal law of all issuers of Medicare Supplement insurance. Any cost associated with these amendments is the result of federal law and not the result of adoption of these amendments.

7. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

   Name: Gregory Y. Harris

   Address: Department of Insurance
   2910 North 44th Street, Suite 210
   Phoenix, Arizona 85018

   Telephone: (602) 912-8451

   Fax: (602) 912-8452

8. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

   Date: June 10, 1996

   Time: 10 a.m.

   Location: Department of Insurance
   2910 North 44th Street, Suite 210
   Phoenix, Arizona 85018

   Nature: Oral proceeding for amendment of the rule. The Department will accept written comments which are received by 5 p.m. on June 10, 1996, or postmarked no later than that date.

9. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
   Not applicable.

10. Incorporations by reference and their location in the rules:
    Not applicable.

11. The full text of the rule follows:

TITLE 20. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Applicability and Scope

A. Except as otherwise specifically provided in R20-6-1104, R20-6-1109, R20-6-1110, R20-6-1113, and R20-6-1118, this Article shall apply to:
   1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof; and
   2. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This Article shall not apply to a policy or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations or combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organizations.

R20-6-1102. Definitions

1. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
2. "Applicant" means:
   a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
   b. In the case of a group Medicare supplement policy, the proposed certificate holder.
3. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is 1 visit.
4. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
5. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

6. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.
7. "Compensation" means any pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders' fees.
8. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
9. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
10. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
11. "Issuer" includes insurance companies, fraternal benefit societies, health care services organizations, hospital and medical service associations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
12. "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
13. The "Medicare Handbook" shall refer to the publication distributed by the United States Department of Health and Human Services, Health Care Financing Administration, describing Medicare benefits available and premium, deductible, and coinsurance amounts payable.
14. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
15. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
16. "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber or member contract of hospital and medical service associations or health care services organizations, other than a policy issued pursuant to a contract under Section 1876 ~~or Section 1833~~ of the federal Social Security Act (42 U.S.C. 1395 et seq.) or an issued policy under a demonstration project ~~authorized pursuant to amendments to the federal Social Security Act~~ specified in 42 U.S.C. § 1395 Subsection (g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.
17. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.
18. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.
19. "Restricted network provisions" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.
20. "Service area" means the geographic area within which an issuer is authorized to offer a Medicare Select policy.

R20-6-1104. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to April 1, 1992

A. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

B. The following standards apply to Medicare supplement policies and certificate and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months after the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.
4. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:
   a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
   b. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.
5. An issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation without prior written authorization from the director. The director may authorize cancellation or nonrenewal for reasons other than nonpayment of premium or material misrepresentation if the director finds that the renewal or continuation of the Medicare supplement policy or certificate would be hazardous or prejudicial to the issuer's certificate holders or policyholders.
6. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (B)(8), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:
   a. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
   b. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as described in R20-6-1105(C).
7. If membership in a group is terminated, the issuer shall:
   a. Offer the certificate holder such conversion opportunities as are described in subsection (B)(6); or
   b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by

the same policyholder, the ~~succeeding~~ issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

C. Minimum benefit standards.

1. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
2. Coverage for either all or none of the Medicare Part A impatient hospital deductible amount;
3. Coverage of Part A Medicare-eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital impatient reserve days;
4. Upon exhaustion of all Medicare hospital impatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;
5. Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells unless replaced or already paid for under Part B;
6. Coverage for the coinsurance amount of Medicare- eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];
7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, unless replaced or already paid for under Part A, subject to the Medicare deductible amount.

R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after April 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.
4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
5. Each Medicare supplement policy shall be guaranteed renewable and
   a. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
   b. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
   c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (B)(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder,
      i. Provides for continuation of the benefits contained in the group policy, or
      ii. Provides for such benefits as otherwise meet the requirements of this subsection.
   d. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
      i. Offer the certificate holder the conversion opportunity described in subsection (B)(5)(c); or
      ii. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
   e. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.
7. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. ~~Upon~~

~~receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.~~

a. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted, effective as of the date of termination of such entitlement, as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

b. Reinstitution of such coverages:

i. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

ii. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

C. Standards for basic "core" benefits common to all benefit plans.

1. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof.

a. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

b. Coverage of Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A-eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, unless replaced;

e. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

D. Standards for additional benefits.

1. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106.

a. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. 80% of the Medicare Part B excess charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. 100% of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

g. Extended outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the 1st 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive medical care benefit: Coverage for the following preventive health services:

i. An annual clinical preventive medical history and physical examination that may include tests and services described in subsection (D)(1)(i)(ii) and patient education to address preventive health care measures.

ii. Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) Fecal occult blood test and/or digital rectal examination;

(2) Mammogram;

(3) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

(4) Pure tone, air only, hearing screening test, administered or ordered by a physician;

(5) Serum cholesterol screening every 5 years;

(6) Thyroid function test;

(7) Diabetes screening.

iii. Influenza vaccine administered at any appropri-

ate time during the year and tetanus and diphtheria booster every 9 years.

iv. Any other tests or preventive measures determined appropriate by the attending physician.

v. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

i. Coverage requirements and limitations

(1) At-home recovery services provided must be primarily services which assist in activities of daily living.

(2) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(3) Coverage is limited to:

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment,

(b) The actual charges for each visit up to a maximum reimbursement of $40 per visit.

(c) $1,600 per calendar year,

(d) Seven visits in any 1 week,

(e) Care furnished on a visiting basis in the insured's home,

(f) Services provided by a care provider as defined in R20-6-1102(A)(4),

(g) At-home recovery visits while the insured is covered under the policy of certificate and not otherwise excluded,

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than 8 weeks after the service date of the last Medicare-approved home health care visit.

(4) Coverage is excluded for:

(a) Home care visits paid for by Medicare or other government programs; and

(b) Care provided by family members, unpaid volunteers, or providers who are not care providers.

k. New or innovative benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits which do not violate any applicable provision of A.R.S. Title 20, or otherwise conflict with this Article and are in addition to the benefits provided in a policy or certificate that otherwise comply with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, are offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

R20-6-1108. Open Enrollment

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant ~~where~~ in the case of an application for ~~such~~ a policy or certificate that is submitted prior to or during the 6-month period beginning with the 1st day of the 1st month in which an individual ~~who~~ is 65 years of age or older ~~1st~~ and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age.

B. Except as provided in R20-6-1119(A), shall not be construed as preventing the exclusion of benefits under a policy, during the 1st 6 months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before ~~it~~ the coverage became effective.

R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium

A. Loss ratio standards.

1. A Medicare supplement policy or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

a. At least 75% of the aggregate amount of premiums earned in the case of group policies, or

b. At least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health care services organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For policies issued prior to December 18, 1991, expected claims in relation to premiums shall meet:

a. The originally filed anticipated loss ratio when combined with the actual experience since inception;

b. The appropriate loss ratio requirement from subsec-

tion (A)(1) when combined with the actual experience beginning with April 28, 1996, to date; and

c. The appropriate loss ratio requirement from subsection (A)(1) over the entire future period for which the rates are computed to provide coverage.

B. Refund or credit calculation.

1. An issuer shall collect and file with the Director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.
2. If on the basis of the experience as reported the benchmark ratio since inception exceeds the adjusted experience ratio since inception, then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.
3. For the purposes of this Section, policies or certificates issued prior to December 18, 1991, the issuer shall make the refund or credit calculation separately for all individual policies combined and all other group policies combined for experience after April 28, 1996. The 1st such report shall be due by May 31, 1998.
~~3.~~4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds .5% of the annualized premium in force as of December 31 of the reporting year. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate not less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates.

1. An issuer of Medicare supplement policies or certificates issued in this state before or after the effective date of this rule shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected 3rd-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.
2. Prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director:
   a. Premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.
      i. An issuer shall make premium adjustments to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.
      ii. If an issuer fails to make premium adjustments in accordance with this rule, the Director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this rule.
   b. Any riders, endorsements or policy forms needed to modify the Medicare supplement policy or certificate to eliminate benefit duplications with Medicare. Such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public hearings. The Director may conduct a public hearing or hearings to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. The Director shall give notice of the hearing in accordance with A.R.S. § 20-163.

R20-6-1113. Required Disclosure Provisions

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be captioned as a renewal or continuation provision and shall appear on the 1st page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.
2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary", or words of similar import.
4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
6. a. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense-incurred or indemnity basis, ~~other than incidentally,~~ to a person or persons eligible for Medicare ~~by reason of age~~ shall provide to ~~such~~ those applicants a ~~Medicare Supplement Buyer's~~ Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the ~~Buyer's~~ Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Article. Except in the case of direct response issuers, delivery of the ~~Buyer's~~ Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the ~~Buyer's~~ Guide shall be obtained by the issuer. Direct response issuers shall deliver the ~~Buyer's~~ Guide to the applicant upon request but not later than at the time the policy is delivered.
   b. For the purposes of this Section, form means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.
1. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. Such notice shall:
   a. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
   b. Inform each policyholder and certificate holder as to when any premium adjustment is to be made due to changes in Medicare.
2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.
3. Such notices shall not contain or be accompanied by any solicitation.

C. Outline of coverage requirements for Medicare supplement policies.
1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and
2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12- point type, immediately above the company name:

   "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."
3. The outline of coverage provided to applicants pursuant to this rule consists of 4 parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-J shall be shown on the cover page, and the plan or plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.
4. The outline of coverage shall include the items in the order prescribed in Appendix B.

D. Notice regarding policies or certificates which are not Medicare supplement policies.
1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; ~~or~~ a policy issued pursuant to a contract under Section 1876 ~~or Section 1833~~ of the federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; ~~basic, catastrophic, or major medical expense policy; single premium nonrenewable policy~~ or other policy identified in R20-6-1101(B) of this Article, issued for delivery in this state to persons eligible for Medicare ~~by reason of age~~ shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. ~~Such~~ The notice shall either be printed or attached to the 1st page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the 1st page of the policy or certificate delivered to insureds. ~~Such~~ The notice shall be in not less than 12-point type and shall contain the following language:

   "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the ~~Medicare Supplement Buyer's~~ Guide to Health Insurance for People with Medicare available from the company.
2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection D(1) shall disclose, using the applicable statement in Appendix F, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

R20-6-1114. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the questions set forth in Appendix C, designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

B. Agents shall list any other health insurance policies they have sold to the applicant.
1. List policies sold which are still in force.

2. List policies sold in the past 5 years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by subsection (D) of this rule for an issuer shall be provided in substantially the prescribed form in Appendix D in no less than ~~10~~ 12-point type.

APPENDIX B
[12 point]
[COMPANY NAME]
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:
BENEFIT PLAN(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible		Part B Deductible			Part B Deductible			
Part B Excess (100%)					Part B Excess(100%)	Part B Excess(80%)		Part B Excess(100%)
Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
At-Home Recovery			At-Home Recovery			At-Home Recovery		At-Home Recovery
ExtendedDrugs ($3000 Limit)							Basic Drugs ($1250 Limit)	Basic Drugs ($1250 Limit)
Preventive Care				Preventive Care				

APPENDIX B (CONT'D)
PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.
[for agents]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 'The Medicare Handbook' for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]
Review the application carefully before you sign it. Be certain that all information has been properly recorded.
[Include for each plan prominently identified in the cover page a chart showing the services. Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Article. An issuer may use additional benefit plan designations on these charts pursuant to R20-6-1106.]
[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

APPENDIX B (CONT'D)
PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day		$157 a day $0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day		$314 a day $0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0 $0	
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0 $0	
- Durable medical equipment			
First $100 of Medicare-Approved Amounts*	0* $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN C
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $100	$0	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)		
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)		$0
Remainder of Medicare-Approved Amounts	80% 20%	$0	
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0 $0	$250	
Remainder of Charges	$0 80% to a lifetime maximum benefit of $50,000	$50,000 lifetime maximum	20% and amounts over

APPENDIX B (CONT'D)
PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to recieve these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$100
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-Approved Amounts *	$0		$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $100	$0	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 100%	$0	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)		
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amount *	$0 $100 (Part B Deductible)	$0	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 80%	20%	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0 $0	
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0 $0	
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0 $0	
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0 $0	
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 100%	$0	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0 $250	
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0 All costs	
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0 $250	
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out patient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $100	$0	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 100%	$0	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)	$0	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)	$0	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS			PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE					
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan					
- Benefit for each visit	$0	Actual Charges to $40 a visit		Balance	
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week			
- Calendar year maximum	$0	$1,600			
OTHER BENEFITS					
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE					
First $250 each calendar year	$0	$0	$250		
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit		50%	
Over $6,000 each calendar year	$0	$0	All costs		
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE					
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare					
First $120 each calendar year	$0	$120			$0
Additional charges	$0	$0	All costs		

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS (continued)			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX C

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

~~2~~3. ~~If you are 65 or older, you~~ You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

~~3~~4. The benefits and premiums under your Medicare supplement policy ~~will~~ can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

~~4~~5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force, ~~including health care service contract, health maintenance organization contract~~?
   a. If so, with which company?
   b. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

2. Do you have any other health insurance ~~policies~~ coverage that provides benefits ~~which~~ similar to this Medicare supplement policy [certificate] ~~would duplicate~~?
   a. If so, with which company?
   b. What kind of policy?

~~3. If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?~~

~~4~~3. Are you covered ~~by~~ for medical assistance through the state Medicaid program:?
   a. As a Specified Low Income Medicare Beneficiary (SLMB)?
   b. As a Qualified Medicare Beneficiary (QMB)?
   c. For full Medicaid Benefits?

APPENDIX D
NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [company name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully, compare it with all accident and sickness coverage you now have. ~~Terminate your present policy if~~ If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. ~~The replacement of insurance involved in this transaction does not duplicate coverage.~~ To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits
____ No change in benefits, but lower premiums
____ Fewer benefits and lower premiums
____ Other (please specify) _____

_____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

Appendix F

MEDICARE DUPLICATION DISCLOSURE STATEMENTS

Instructions for use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Federal law, P.L. 103-432, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/Casualty and Life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. The federal law does not pre-empt state laws that are more stringent than the federal requirements.

7. The federal law does not pre-empt existing state form filing requirements.

[For policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that reimburse expenses incurred for specifiied disease(s) or other specified impairment(s). This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For long-term care policies providing both nursing home and non-institutional coverage.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long-term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance, available from the insurance company.*
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For long-term care policies providing nursing home benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance, available from the insurance company.*
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing home care benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance, available from the insurance company*.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.